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ABSTRACT

This article is written to help career practitioners better understand mental health problems, or psychopathology from a career case-study perspective. After an introduction to the core concepts of psychopathology, three case studies of increasing complexity will be discussed to illustrate the effects that mental health problems may have on a person's career. (Author)

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Are They Nuts? When Psychopathology Interferes with Career Issues

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INTRODUCTION

Most discussions of psychopathology (mental health problems) begin by trying to articulate what is normal and what is abnormal. These discussions frequently become very philosophical, and eventually people reach a consensus on how difficult it is to distinguish normal from abnormal. Fortunately, a tremendous amount of work has gone into defining various mental health disorders. This work has been conveniently complied into a manual known as the *Diagnostic and Statistical Manual of Mental Disorders IV* (*DSM IV,* 1994). This manual lists various mental disorders, describes their prevalence and causes, outlines the criteria for diagnosis, and provides information on suggested treatment plans. This article will provide a brief overview of the *DSM IV* and then discuss three case studies of increasing complexity to illustrate how mental health problems may affect a person's career. To ensure confidentiality, all identifying information in the case studies has been omitted or changed.

THE *DSM IV*

Psychologists and psychiatrists who use the *DSM IV* will frequently provide a clinical picture of a client's mental health concerns through a multi-axial assessment. The multi-axial assessment is composed of five axes. The first axis is known as Axis I. The disorder of clinical attention is listed on Axis I. For example, disorders such as major depression and generalized anxiety disorder are listed on Axis I. Personality disorders and mental functioning are listed on Axis II. Personality dimensions and mental functioning are thought to inform or complicate the treatment of Axis I disorders. For example, personality factors such as obsessive-compulsive personality disorder may result in or make conditions such as depression or anxiety worse when the client is obsessed with work, perfection, and over-achieving performance. Similarly, an avoidant personality may avoid trying things that may generate feelings in contrast to anxiety or depression. Such personality factors are thought to interfere with or complicate the treatment of Axis I concerns. Medical conditions (e.g., asthma, cancer, epilepsy) are listed on Axis III. Psychosocial stressors (e.g., financial problems, legal problems, housing problems) are listed on Axis IV. A global assessment of functioning score is reported on Axis V. The *DSM IV* lists descriptors for the various scores on the Global Assessment of Functioning Scale. The scores range from 0 to 100, with 0 being the lowest score and 100 indicating the best level of functioning. A score of 50 or lower indicates serious mental health concerns.

Psychologists and psychiatrists who provide a diagnosis through the *DSM IV* will ensure that the client meets the criteria for the disorder as listed in the *DSM IV.* Information pertaining to client symptoms will come from a variety of sources including the client's reported history, collateral sources of information from significant others, employers, employment or educational records, and psychometric test data. Essentially, the clinician providing the diagnosis will ensure that the

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person's symptoms are so severe that the client's social and/or occupational functioning has become impaired. With a brief overview of the *DSM IV* in place, this article will now use the multi-axial assessment to describe three case studies illustrating how issues of psychopathology may affect a person's career.

CASE STUDY #1

The *DSM IV* multi-axial assessment of the first case study is as follows:

Axis I Major depression
Axis II Nothing
Axis III Nothing
Axis IV Occupational and financial problems
Axis V Global assessment of functioning (on intake) 60

This client was referred by the client's family physician because the client's depressive symptoms did not subside after three months of treatment with anti-depressants. The client's symptoms included severely interrupted sleep, low energy levels, procrastination, pessimism, irritable and emotional mood, withdrawal from people and pleasurable activities, poor memory and concentration, and a decreased interest in sex.

Assessment was performed by using the clinical interview, the Beck Depression Inventory, the Beck Anxiety Inventory, Subjective Units of Discomfort Scale monitoring, and Analogue Recording of Self-Referenced Thoughts. The clinical interview determined the existence of the symptoms listed above, while the Beck Depression Inventory confirmed a severe degree of depression. The Beck Anxiety Inventory did not confirm the presence of anxiety. Subjective Units of Discomfort Scale monitoring asks clients to record their level of depression on a scale of 0–10. The Subjective Units of Discomfort Scale monitoring revealed that this client subjectively experienced a large degree of depressive symptoms, which were causing great distress.

Based on the cognitive therapy idea that people who are depressed are frequently viewing their situations in an overly negative light (Ellis, 1973; 1979), the client was asked to record his thoughts in a journal (Analogue Recording of Self-Referenced Thoughts). The client's journalling revealed a significant number of negative thoughts about career and money, being a loser for not having a full-time job, ascribing one's worth to having a full-time job, being unable to see employment from any perspective except full-time work, and thinking his father thought of him as a loser for not having a full-time job.

According to cognitive therapists such as Ellis (1973; 1979), clients frequently manufacture their own emotional turmoil by misinterpreting their situations, and they make their emotional status worse by misinterpretation, magnification, and catastrophic thinking about their

own circumstances. Such thinking is frequently unsupported by environmental evidence. Thus, cognitive therapists encourage clients to seek evidence to confront their mistaken assumptions. In this case, the client was asked to read *Job Shift* by William Bridges (1994) and *Boom, Bust and Echo* by David Foot (1996). *Job Shift* was chosen to try to get the client to view work in ways other than full-time employment, and *Boom, Bust and Echo* was chosen to provide some demographic explanations about availability of full-time employment for the client's father's age group versus that of the client's age group. These sources proved to be very valuable in allowing the client to restructure beliefs about putting pieces of work together to form a career and to refute his father's criticism. The client quickly became very adept at putting pieces of work together and was, therefore, able to eliminate financial concerns. The client's mood improved dramatically, no longer meeting the criteria for a diagnosis of major depression.

CASE STUDY #2

The *DSM IV* multi-axial assessment of the second case study is as follows:

Axis I Generalized anxiety disorder
Axis II Obsessive-compulsive personality disorder, dependent personality disorder
Axis III Many health-related complaints
Axis IV Occupational problems
Axis V Global assessment of functioning 50 (serious symptoms)

This client was referred for assessment due to ongoing interpersonal difficulties with co-workers. Supervisors and managers reported that she had done great work while on night shift where she worked alone. It was reported that the client did such great work that she was rewarded by being moved to the day shift where the job required her to interact with others. On the day shift, the client was in a position to see what the night staff had produced. Having obsessive-compulsive personality disorder was helpful to the client on the night shift where she worked alone. In other words, people with obsessive-compulsive personality disorder think that it is important to do a perfect job on everything, that flaws, defects, or mistakes are intolerable, and that people should do things their way. This led to perfectionist tendencies and subsequently to perfect work. Possessing a dependent personality disorder, as well, the client thought that one must be subservient in order to maintain contact and access to someone who is perceived to be stronger than or superior to the client. This way of thinking actually helped the client to perform well when she was left to work on her own and it resulted in her getting a great deal of praise from the supervisor with whom she had developed a dependent relationship. Unfortunately, when the client was asked to move to the day shift (where she was expected to examine the work of those on the night shift) she obsessed about how things were not done to her level of expectations. The client continually went to the boss to complain

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about many imperfections in the work of co-workers and she began to lose credibility with her supervisor and co-workers. In fact, the client began to be seen as someone who had unreasonable expectations. This led to an increase in her anxiety levels and to rigidity about how incompetent her co-workers were. Ultimately, this led to so much conflict amongst co-workers that an outside consultation was requested with the writer.

Assessment was performed through many interviews with the client, co-workers, supervisors, and managers. The interview data, along with psychometric testing via the Millon Clinical Multi-Axial Inventory III and the client's reported history supported the above diagnoses. With the case conceptualization in place, it became clear to the writer that we could de-escalate the conflict in the work environment by moving the client back to night shift, giving her her own set of responsibilities and praising her for her diligence in completing assigned tasks so well. This resulted in an immediate reduction in conflict among the co-workers and the client reported a significant reduction in anxiety and feeling happy to be back in a role that she felt good about.

CASE STUDY #3

The unsubstantiated *DSM IV* multi-axial assessment of the third case study is as follows:

Axis I Major depression
Axis II Narcissistic personality disorder, obsessive-compulsive personality disorder, histrionic personality disorder
Axis III Nothing
Axis IV Occupational problems
Axis V Global assessment of functioning 50 (serious symptoms)

Case study #3 was referred by the client's family physician after his client's licence to practise medicine was being revoked because he was found psychologically unsafe to practise medicine. The client had a history of disagreeing with the executive members of the professional association. He then lost a significant other. Later he was called by a member of the professional association and told that since he had lost a significant other, the association was worried about his well-being and it was suggested that he go to a treatment centre in the United States for specialized assessment and treatment. Without the client's knowledge, the association had sent detailed information about interpersonal conflicts between the client and the association. Essentially, the association wanted to know if the member was safe to practise medicine and wanted the specialized program to say the client was not safe to practise so the association could withdraw the client's licence to practise and therefore get rid of a problematic member.

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The writer had just met with the client once, when asked to participate in a conference call with the director of the United States assessment centre, the client's family physician, and the registrar of the client's professional association. The director of the assessment centre had argued that the client was unsafe to practise for two reasons. First, the client's major depression was so severe that it interfered with his ability to concentrate on medical work. In other words, the client's memory and concentration were so impaired that he was a risk to patients. Second, the client's Axis II complications (personality disorders) were so severe and so engrained that treatment of the major depression would be very difficult, if not impossible. The centre recommended that the client's licence to practise be revoked and that the client be enrolled in a 30-day treatment program at a different treatment centre to work on the major depression and then go into a long-term treatment program at yet another facility to work on the personality disorders. The director stated that all of the test data to support the diagnoses and rationale would be sent to the writer the next day and that such information would substantiate the recommendations of the centre.

Unfortunately, the writer never received such documentation to support the claims made in the telephone conference. The client, the writer, and the family physician continued to request that the information be sent. A Canadian judge also requested that the information be sent and this request was also ignored. Unable to obtain the assessment data from the United States, the writer referred the client to a forensic psychologist and to a forensic psychiatrist. A new and comprehensive assessment was performed.

To assess the cognitive functioning of the client, the Weschler Adult Intelligence Scale III and the Weschler Memory Scales were administered. The client scored around the 84th percentile on all of the subtests of these cognitive tests, indicating no problems with concentration, memory, or overall cognitive functioning. To assess for the presence of personality disorders and major depression, clinical interviews were conducted along with administration of the Beck Depression Inventory, the Millon Multi-axial Clinical Inventory III, and the Minnesota Multiphasic Personality Inventory II. None of these assessments supported the presence of either the major depression or the personality disorders reported by the United States program. This information, along with the fact that the United States program never produced any documentation to support their diagnosis, led the Canadian judge to overrule the decision of the professional association to revoke the client's medical licence. The physician was immediately reinstated and successfully resumed medical practice.

The actual *DSM IV* diagnosis of the client in case study #3 was:
Axis I Bereavement
Axis II Nothing

Axis III Nothing
Axis IV Legal problems
Axis V Global assessment of functioning 80

In other words, the client was quite naturally suffering from bereavement, having lost his significant other, but this was in no way interfering with his ability to work and to practise medicine.

SUMMARY

This paper has tried to introduce the reader to the concept of psychopathology (mental health problems) and to illustrate through a case study approach how issues of psychopathology may affect the careers of individuals. Each case study showed different manifestations of psychopathology and illustrated how the careers of individuals may be differentially affected. Unfortunately, the article also exemplified how we cannot simply take for granted the diagnoses that may be communicated to us. Such examples illustrate the need for all of us in the helping professions to have some basic level of understanding of such issues so we can competently advocate on behalf of our clients.

The writer made several phone calls to many psychologists across the country when trying to figure out what happened in case study #3. The writer found many psychologists have encountered similar difficulties with clients who have been members of professional associations that were de-listed in a similar manner. Most psychologists across Canada reported that their clients had given up the fight and simply withdrew from their means of employment. Obviously, this information highlights the importance, across the helping professions, for maintaining diligence in dealing with clients suffering from such unwarranted persecution in their attempt to belong in the world of work. Such examples also illustrate the lengths to which those in positions of power may go to prove how wrong or crazy those who choose to disagree with them are.

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